BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Gary James Shima, M.D.	)	Case No. 10-2013-233259
Physician's and Surgeon's Certificate No. G14742	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 25, 2017.

IT IS SO ORDERED: July 28, 2017.

MEDICAL BOARD OF CALIFORNIA

Michelle Anne Bholat MD

Michelle Bholat, M.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
MARTIN W. HAGAN
Deputy Attorney General
State Bar No. 155553
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9405
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GARY JAMES SHIMA, M.D.** **1529 Grand Avenue, Suite B** **San Marcos, CA 92078** **Physician's and Surgeon's Certificate No. G14742** Respondent.	Case No. 10-2013-233259 OAH No. 2016120821 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

2. Respondent Gary James Shima, M.D. (Respondent) is represented in this proceeding by attorney Kevin D. Cauley, Esq., whose address is: 624 South Grand Avenue, 22nd Floor, Los Angeles, California 90017.

3. On or about May 22, 1968, the Board issued Physician's and Surgeon's Certificate No. G14742 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 10-2013-233259, and will expire on September 30, 2018, unless renewed.

JURISDICTION

4. On June 23, 2016, Accusation No. 10-2013-233259 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on June 23, 2016. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 10-2013-233259 is attached as exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 10-2013-233259. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent agrees that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation No. 10-2013-233259, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G14742 to

disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

9. Respondent further agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition for revocation of probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 09-2013-235028 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California or elsewhere.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. G14742 is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

11. The *prima facie* admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board or other professional licensing agency in the State of California is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

////

13. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree the Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order:

////

////

////

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G14742 issued to Respondent Gary James Shima, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. **CONTROLLED SUBSTANCES - PARTIAL RESTRICTION**. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for the following: Schedule III drug (Testosterone only and no other Schedule III drugs) and all Schedule V drugs of the Act. As a condition precedent to Respondent ordering, prescribing, dispensing, administering, furnishing, or possessing Schedule III (Testosterone only) or any Schedule V drugs of the Act, Respondent must submit a certification of successful completion to the Board or its designee of the Prescribing Practices Course term and condition number 3, set forth below.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the

patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

2. **CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES**. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. **PRESCRIBING PRACTICES COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing

practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **CLINICAL COMPETENCE ASSESSMENT PROGRAM**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the

scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

5. **MONITORING - PRACTICE**. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees

with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and

education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. **PROHIBITED PRACTICE**. During probation, Respondent is prohibited from providing any prescriptions to any patient for the purpose of treating their chronic pain. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from providing any prescriptions to any patient for the purpose of treating their chronic pain. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

7. **NOTIFICATION**. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. **SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES**. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

////

9. **OBEY ALL LAWS**. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. **QUARTERLY DECLARATIONS**. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. **GENERAL PROBATION REQUIREMENTS**.

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice ,Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

////

////

12. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE**. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. **NON-PRACTICE WHILE ON PROBATION**. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or

Controlled Substances; and Biological Fluid Testing

14. **COMPLETION OF PROBATION**. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. **VIOLATION OF PROBATION**. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. **LICENSE SURRENDER**. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. **PROBATION MONITORING COSTS**. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

////

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Kevin D. Cauley, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 05/19/17

GARY JAMES SHIMA, M.D.
Respondent

I have read and fully discussed with Respondent Gary James Shima, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 5-19-17

KEVIN D. CAULEY, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 5/19/2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

SD2016701162
81693705.docx

Exhibit A

Accusation No. 10-2013-233259

KAMALA D. HARRIS
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
MARTIN W. HAGAN
Deputy Attorney General
State Bar No. 155553
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2094
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GARY JAMES SHIMA, M.D.** **1529 Grand Avenue, Suite B** **San Marcos, CA 92078** **Physician's and Surgeon's Certificate No. G14742,** Respondent.	Case No. 10-2013-233259 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 22, 1968, the Medical Board issued Physician's and Surgeon's Certificate Number G14742 to Gary James Shima, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on September 30, 2016, unless renewed.

////

////

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, be placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded and ordered to complete relevant educational courses, or have such other action taken in relation to discipline as the Board or an administrative law judge deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"...."

6. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

////

7. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

8. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

9. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

11. Section 2285 of the Code states:

"The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitutes unprofessional conduct. This section shall not apply to the following:

"(a) Licensees who are employed by a partnership, a group, or a professional corporation that holds a fictitious name permit.

"(b) Licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

"(c) An outpatient surgery setting granted a certificate of accreditation from an accreditation agency approved by the medical board.

"(d) Any medical school approved by the division or a faculty practice plan connected with the medical school."

12. Section 2286 of the Code states:

"It shall constitute unprofessional conduct for any licensee to violate, to attempt to violate, directly or indirectly, to assist in or abet the violation of, or to conspire to violate any provision or term of Article 18 (commencing with Section 2400), of the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), or of any rules and regulations duly adopted under those laws."

13. Section 2400 of the Code states:

"Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic."

14. Section 2406 of the Code states:

"A medical corporation or podiatry corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are physicians and surgeons, psychologists, registered nurses, optometrists, podiatrists, chiropractors, acupuncturists, naturopathic doctors, physical therapists, occupational therapists, or, in the case of a medical corporation only, physician assistants, marriage and family therapists, clinical counselors, or clinical social workers, are in compliance with the Moscone-Knox Professional Corporation Act, the provisions of this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

"With respect to a medical corporation or podiatry corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the board."

15. Section 2415 of the Code states:

"(a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group,

or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.

"(b) The division or the board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:

"(1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.

"(2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.

"(3) The name under which the applicant or applicants propose to practice is not deceptive, misleading, or confusing.

"(c) Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff. The notice shall be displayed at each place of business identified in the permit.

"(d) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with that medical school.

"(e) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section 2420) pertaining to renewal of licenses, except the division shall establish procedures for the renewal of fictitious-name permits every two years on an anniversary basis. For the purpose of the conversion of existing permits to this schedule the division may fix prorated renewal fees.

"(f) The division or the board may revoke or suspend any permit issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

"(g) A fictitious-name permit issued to any licensee in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

"(h) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

"(i) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine and shall adopt and administer regulations specifying appropriate podiatric medical name designations.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients C.D., W.B., C.B. and M.O., as more particularly alleged hereinafter:

PATIENT C.D.

17. On or about April 16, 2001, respondent began treating patient C.D., a then-39 year old female with diagnoses which included, but were not limited to, muscoskeletal pain, chronic pain, anxiety and hypothyroidism.[1]

18. On or about April 18, 2001, to April 26, 2001, patient C.D. was treated for drug withdrawal and had follow up with respondent in regards to her drug withdrawal on or about May 2, 2001, and May 8, 2001. In addition to patient C.D.'s treatment for drug withdrawal, there were

[1] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

other indicators of the risk of patient C.D. abusing or diverting controlled substances including, but not limited to, a notation about her driving under the influence on or around July 18, 2005, requesting early refills and being dishonest when requesting an early refill.[2] Respondent continued to treat patient C.D. sporadically between on or about May 14, 2001, through May 2008.

19. On or about May 9, 2008, a note was written to Savon pharmacy indicating patient C.D. was to see a pain specialist and this was the last refill of hydrocodone APAP for the patient. Respondent indicated that he would continue to prescribe alprazolam (Xanax) to patient C.D.

20. On or about August 23, 2010, respondent saw patient C.D. and provided her with a H/C Meyers cocktail (intravenous micronutrient therapy). Her blood pressure was recorded as 140/70 and pulse as 83. Patient C.D.'s elevated blood pressure was not addressed by respondent. A prescription was issued for hydrocodone APAP (acetaminophen)[3] 10/650 mg (#180) 1 tab 6 times a day. The note for this visit is cursory. A physical examination was not performed or documented and respondent did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled substances or taking additional controlled substances.

////

[2] Respondent's handwritten controlled substances log has an entry for June 7, 2007, which states, in pertinent part, that patient C.D. "called trying to get her [Vicodin] early because she was 'going to the desert' with her husband. However, she told D., the pharmacist at Ramona Pharmacy that she was 'going to Texas.' Dr. Shima is upset with her for playing games and is insisting on the original agreement only [illegible] every 10 days."

[3] Hydrocodone APAP (Lorcet®, Lortab® and Vicodin®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain.

21. On or about September 2, 2010, respondent issued patient C.D. a prescription for carisoprodol (Soma) 350 mg (#120) 1 tab 4 times a day. There is no office visit or phone consultation chart note associated with this visit and the record of the prescription is limited to respondent's "Order" log contained within his medical records for patient C.D.

22. On or about September 8, 2010, patient C.D. had a seizure and was taken by ambulance to Pomerado Hospital and her medications were continued. The note for this visit states "discussed medication routine – controlled by husband" with no further detail.

23. On or about September 9, 2010, respondent issued a prescription to patient C.D. for alprazolam[4] (Xanax) 1 mg (#210) 1 tab 7 times a day. There is no record of any office visit or phone consultation on this date nor are there any chart notes indicating any recent physical examination, any specific rationale for the prescription, assessment regarding the efficacy of the controlled substances being prescribed to respondent or any informed consent related to the controlled substances.

24. On or about September 20, 2010, respondent issued a prescription to patient C.D. for hydrocodone APAP 10/650 mg (#180) 1 tab 6 times a day. There is no record of any office visit or phone consultation on this date nor are there any chart notes indicating any recent physical examination, any specific rationale for the prescription, assessment regarding the efficacy of the controlled substances being prescribed to respondent or any informed consent related to the controlled substances.

25. On or about September 22, 2010, the patient requested a letter from respondent to be sent to her driving under the influence (DUI) monitor confirming that he was issuing her hydrocodone APAP and alprazolam (Xanax) prescriptions. The note for this visit states, among other things, "Do not fill [carisoprodol] SOMA[5] anymore." Respondent wrote a letter to the DUI

---

[4] Alprazolam (Xanax®), a benzodiazepine, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of anxiety and panic attacks.

[5] Carisoprodol (Soma®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the

(continued...)

monitor on the same date which stated, in pertinent part, "This is a verified affidavit that I prescribe for Ms. [C.D.], hydrocodone 10 mg with acetaminophen 650 mg and alprazolam 1 mg on a long-term basis for numerous musculoskeletal injuries and associated anxiety."

26. On or about October 8, 2010, respondent had a phone consult with patient C.D. The note for this visit indicates "Trouble with [her husband] drinking too much after mother['s] funeral back home on Tuesday" and "may have to go to better home." The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled substances or taking additional controlled substances.

27. During the period of on or about October 8, 2010, through December 31, 2011, respondent was maintained on alprazolam (Xanax) 1 mg (#210) at 7 tablets per day and hydrocodone APAP 10/650 mg (#180) 6 tabs a day. According to what can be discerned from respondent's medical records over this period of time, respondent had contact with patient C.D. on January 4, 2010 (office visit); April 28, 2011 (office visit); June 27, 2011 (phone consult); July 1, 2011 (phone consult); July 5, 2011 (office visit) and November 18, 2011 (office visit). Respondent authorized an early refill on December 23, 2010 for alprazolam (Xanax) 1 mg (#210) with no clear documentation of the reason for the early refill; and early refills for APAP (Lorcet) 10/650 mg (#180) with no clear documentation of the reason for the early refills. A copy of the

---

(...continued)
treatment of acute and painful musculoskeletal conditions. According to the Drug Enforcement Administration (DEA) Office of Diversion Control, Carisoprodol (Soma®) "abuse has escalated in the last decade in the United States" and "continues to be one of the most commonly diverted drugs" The DEA warns that "[w]ith prolonged abuse at high dosage, carisoprodol can lead to tolerance, dependence and withdrawal symptoms in humans." (See generally, www.deadiversion.usdoj.gov/drug_chem_info/carisoprodol/carisoprodol.pdf)

CURES report for patient C.D. indicates that other physicians besides respondent were also prescribing controlled substances to patient C.D. beginning in approximately April 2011, which should have been a further indication that respondent was potentially abusing or diverting controlled substances.[6] The notes for the office visits or phone consults are cursory and difficult to decipher. A Physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure C.D. was not diverting controlled substances or taking additional controlled substances.

28. On or about January 4, 2012, respondent had a phone consultation with patient C.D. The note for this visit indicates, among other things, that there was a discussion about a 3-way conference call with patient C.D., another person, and respondent to discuss "family stress" issues. Another section of the note states patient C.D.'s husband was abusing alcohol and "conclusion he needs 'Professional Help' with alcohol – and get job." The note also indicates respondent was refilling a prescription for alprazolam (Xanax) 1 mg (#210) at 7 tablets per day and hydrocodone APAP 10/650 mg (#180) 6 tabs a day. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, prior imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled

[6] The CURES report for patient C.D. for the period of April 18, 2011, through April 18, 2014, indicates that other physicians were also prescribing controlled substances to her including, but not limited to, Alprazolam, Norco, Diazepam and Vicodin.

substances or taking additional controlled substances.

29. Between on or about January 5, 2012, to December 9, 2012, there was no documented contact with patient C.D. in regard to any phone consults and/or office visits. On or about July 24, 2012, respondent noted there was an issue with missing pills[7] which was another indicator of possible abuse and/or diversion of controlled substances. Despite the fact that there was no contact with patient C.D., over this approximate eleven month period, respondent maintained patient C.D. on alprazolam (Xanax) 1 mg (#210) 7 tablets per day, hydrocodone APAP 10/650 mg (#180) 6 tabs a day; and, on January 20, 2012, started prescribing her carisoprodol (Soma) 350 mg (#120) 1 tab q.i.d. (four times a day) on a near monthly basis. There is no medical record documentation for January 20, 2012, to indicate why patient C.D. was started on the carisoprodol (Soma). The combination of alprazolam (Xanax), hydrocodone APAP and carisoprodol (Soma) is a powerful combination of controlled substances and dangerous drugs known as "Houston cocktail," "trio" and/or the "holy trinity" that is typically not medically justified.[8]

30. On or about December 10, 2012, respondent had an office visit with patient C.D. The note for this visit indicates patient C.D. was having difficulty with the hydrocodone APAP 10/650 mg.[9] Respondent's note states he would prescribe hydrocodone APAP (Vicodin) 5/500 mg (#240) 2 tabs q.i.d. for pain. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding

---

[7] Respondent's cursory and handwritten log of controlled substances has an entry for July 24, 2012, which states "Issues [with] missing pills." No further details were provided.

[8] "Taking these three drugs in combination is typically not medically justified. When taken together these medications may give users a feeling of euphoria similar to heroin. As a result, this prescription drug combination, which may be referred to as 'Houston Cocktail,' 'Holy Trinity,' or 'Trio,' is subject to abuse and has resulted in deaths." (M. Forrester, Ingestions of Hydrocodone, Carisprodol, and Alprazolam in Combination Reported to Texas Poison Centers, Journal of Addictive Diseases, 30:110-115, 2011.)

[9] There is a notation, which is difficult to decipher, in the note for this visit that appears to state "allergies to Lorcet" with no further details.

the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled substances or taking additional controlled substances.

31. On or about December 31, 2012, respondent wrote a letter on patient C.D.'s behalf to one of the branches of the San Diego County Superior Court which stated "This patient has chronic disabilities and on medications to control chronic pain and anxiety. She is not able to appear in court and face the rigors of the court process."

32. On or about January 4, 2013, respondent issued prescriptions for carisoprodol (Soma) 350 mg (#120) 1 tab q.i.d. (four times a day) and hydrocodone APAP 5/500 mg (#240) 2 tabs q.i.d.

33. On or about January 9, 2013, respondent had an office visit with patient C.D. There is no medical record for this office visit except for an invoice indicating that patient C.D. received a "H/C Meyer's Cocktail." A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled substances or taking additional controlled substances.

34. During the period of on or about January 10, 2013, to on or about July 7, 2013, there was no documented contact with patient C.D. in regard to any phone consults and/or office visits. Despite the fact that there was no contact with patient C.D., over this approximate seven month period, respondent maintained patient C.D. on alprazolam (Xanax) 1 mg (#210) 7 tablets per day on a near monthly basis, hydrocodone APAP (varying dosages) on a near monthly basis (that were titrated up from approximately 40 mg of hydrocodone per day to 80 mg of hydrocodone per

day);[10] and carisoprodol (Soma) 350 mg (#120) 1 tab q.i.d. (four times a day) on a near monthly basis.

35. On or about July 16, 2013, respondent was sent a letter from a Dr. S.G., Medical Director, Inpatient Alcohol and Drug Treatment, at the Department of Veteran Affairs, San Diego Healthcare System, which advised respondent of the following concerning patient C.D.:

> "This is to inform you that your patient [C.D.] is presently in our inpatient Alcohol and Drug Treatment Program for Alcohol, Opioid, and Benzodiazepine Dependency. Prescribing of medications that have the potential for addiction would be discouraged for this patient."

36. There was no record of any further treatment of patient C.D. after respondent received the letter above concerning patient C.D.'s admission into the drug and alcohol treatment program.

37. Respondent committed gross negligence in his care and treatment of C.D., which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient C.D. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient C.D. without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care;

---

[10] Over this period of time, patient C.D. filled 1 prescription from respondent for hydrocodone APAP 5/500 mg (#240); then 3 prescriptions from respondent for hydrocodone APAP 10/650 mg (#180); and then 3 prescriptions of hydrocodone APAP 10/650 mg (240).

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. despite indications of addiction, without close consultation with an addiction medicine specialist;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. which exceeded generally accepted maximum daily dosages for alprazolam (Xanax) and acetaminophen which increased the risk of harm to patient C.D.;

(h) Respondent failed to properly evaluate and manage patient C.D.'s alleged anxiety, attention deficit and hyperactivity disorder (ADHD) and chronic pain; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient C.D. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

PATIENT W.B.

38. On or about December 29, 2008, respondent began treating patient W.B, a then-47 year old male, with a history of drug abuse (including prior heroin abuse), anxiety and depression.

His diagnoses included, but were not limited to, hepatitis C for nearly three decades, chronic fatigue, rheumatoid arthritis, chronic spine issues, and neck pain radiculopathy. Patient W.B.'s occupation was listed as "disabled" and he reported that he was on a variety of medications including "Methadone 60 mg/day." Patient W.B. was provided with a "Mutual Opioid Treatment Agreement"[11] that both he and respondent signed. Respondent did not periodically review the pain contract with patient W.B. nor was it discussed in detail.

39. During the period of on or about January 13, 2009, to June 18, 2009, respondent had near monthly contact with patient W.B. through six office visits and one phone encounter. During this time frame, respondent issued one prescription of Methadone HCL 10 mg (#180) 6 daily on January 30, 2009 (morphine equivalency dosage of 600 mg) and five prescriptions of hydromorphone (Dilaudid) 8 mg (#360) 3 tabs q.i.d. (four times a day)(morphine equivalency dose of 384 mg) for the remaining months.[12] On February 24, 2009, respondent was provided with x-ray reports for patient W.B. that showed no significant abnormalities.[13] The notes for the office visits or phone consults are cursory and difficult to decipher. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B.

---

[11] The Mutual Opioid Treatment Agreement stated the patient agreed to (1) not share prescriptions with anyone else; (2) not obtain controlled substances from anyone else; (3) not seek other providers for prescriptions; (4) not send prescriptions to numerous pharmacies; (5) regular office/phone follow-ups; (6) urine or blood testing as indicated for opioids; (7) not call for early refills and be responsible for protecting prescriptions; (8) not use any illicit/street drugs; and (9) control excessive use of alcohol. The agreement provided that "violations of any of these conditions may result in terminating my prescription care." This agreement was the same as the one used for patients C.B. and M.O.

[12] The hydromorphone APAP prescriptions were issued on February 24, March 23, April 23, May 21 and June 18, 2009.

[13] The views of the cervical spine showed no abnormalities and the views of the lumbar spine showed mild degenerative changes.

was not diverting controlled substances or taking additional controlled substances.

40. During the period of on or about July 20, 2009, to October 22, 2009, respondent had near monthly contact with patient W.B. through two office visits and two phone encounters. In his note of March 23, 2009, respondent noted that he "reviewed x-rays" but there was no mention of the findings which showed no significant abnormalities. Respondent maintained the patient on hydromorphone (Dilaudid) 8 mg (#360) 3 tabs q.i.d. (four times a day) on a monthly basis (morphine equivalency dosage of 384 mg per day) and also issued prescriptions for bupropion hydrochloride (Wellbutrin SR) 1 tab b.i.d. (twice a day) and zolpidem tartrate (Ambiem) 10 mg (#30) 1 tab daily on July 20, 2009. The notes for the office visits or phone consults are cursory and difficult to decipher. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

41. On or about January 21, 2010, respondent referred patient W.B. out for physical therapy two to three times weekly for four to six weeks for neck pain and radiculopathy. A physical therapy evaluation was conducted on January 25, 2010, which indicated, among other things, "drug abuse" and suicide attempt in the past, multiple neck injuries including a motor vehicle accident in 2007. Patient W.B. completed approximately seven physical therapy visits and quit on or about April 10, 2010, before reaching his physical therapy goals. The discharge summary noted "[patient] quit before any progress could be made, no reason given."

42. On or about May 20, 2010, respondent saw patient W.B. to follow up on "chronic pain syndrome." The notes for this visit indicate, among other things, "fatigue – brain scattered." Respondent prescribed methylphenidate and hydromorphone 8 mg (#360) 3 tabs q.i.d. (morphine equivalency dosage of 384 mg per day). There was no mention of the failed effort at physical

therapy. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

43. On or about June 24, 2010, respondent saw patient W.B. who complained of increase in migraine headaches and "headache almost all month." The note for this visit indicates the patient had seen a chiropractor and done physical therapy but nothing helped. In actuality patient W.B. "quit before any progress could be made, no reason given." Respondent prescribed prolotherapy.[14] The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history (with the exception of an abbreviated reference to a chiropractor referral and the recent physical therapy that the patient quit before reaching treatment goals), pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled substances or taking additional controlled substances.

////

////

[14] Prolotherapy, also called proliferation therapy or regenerative injection therapy is an alternative medicine treatment that uses injection of an irritant solution into ligaments or tendon insertion in an effort to relieve pain.

44. On or about July 2, 2010, respondent saw patient W.B. who complained of tender neck area and headaches. The patient underwent another round of prolotherapy and respondent recommended stretching and applying heat. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

45. On or about July 19, 2010, respondent spoke with patient W.B. over the phone who reported his neck was better but he was still experiencing pain (or his pain was increasing) with no area specified. Respondent prescribed hydromorphone HCL 8 mg (#480) 4 tablets q.i.d. (morphine equivalency dose of 512 mg per day) and a three-month supply of methylphenidate (Ritalin) 20 mg (#270) 4 tabs t.i.d. (three times a day). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

46. On or about August 5, 2010, respondent had an office visit with patient W.B. who complained of a right ear ache, tender neck and headache. Respondent ordered another round of prolotherapy 25 cc and a cortisone injection 10 cc. One of Respondent's notes for this visit indicates an apparent new diagnosis of "fibromyalgia syndrome" with no specifics. The note for this visit is cursory. A physical examination was not performed or documented and respondent

failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

47. On or about August 17, 2010, respondent had an office visit with patient W.B. who complained of increased pain, agitation and anxiety, and fearfulness of being in a rural area. There was no mention of consultation with, or referral to, any mental health professional. Respondent suggested a medical marijuana evaluation and also issued a prescription for hydromorphone HCL (Dilaudid) 8 mg (#480) 4 tabs q.i.d. (morphine equivalency dosage of 512 mg per day). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals (apart from suggesting medical marijuana to the patient who had a history of drug abuse) and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

48. On or about September 16, 2010, respondent had a follow-up office visit for "chronic pain." Respondent refilled patient W.B.'s zolpidem tartrate (Ambien) 10 mg (#90) and issued another prescription for hydromorphone HCL (Dilaudid) 8 mg (#480) 4 tabs q.i.d. (morphine equivalency dosage of 512 mg per day).[15] The note for this visit is cursory. A physical

[15] According to the note for this visit, respondent considered a trial run of Oxycontin instead of the hydromorphone HCL (Dilaudid). However, the prescription for Oxycontin was (continued...)

examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

49. On or about October 12, 2010, respondent had a follow-up office visit with patient W.B. for "chronic pain" and "anxiety syndrome." The note for this visit indicates "will try oxycodone HCL (Oxycontin) 80 mg (#120) two tablets b.i.d. (twice a day) (morphine equivalency dosage of 480 mg per day. Respondent also issued a prescription for methylphenidate (Ritalin) 20 mg (#90) 20 mg, 1 tablet t.i.d. There is no justification for the new prescription of oxycodone (Oxycontin). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

50. On or about October 15, 2010, respondent had an office visit with patient W.B. presumably to deal with medication management issues. The note for this visit indicated that respondent was discontinuing the methylphenidate (Ritalin) 20 mg (#90) 20 mg, 1 tablet t.i.d. prescription and instead issuing a prescription for methylphenidate (Ritalin) 20 mg (#270) 20 mg,

---

(...continued)
voided because there was no generic and the Oxycontin was "too expensive."

1 tablet t.i.d. with an indication that it was a "3 months supply." Respondent also discontinued the oxycodone HCL (Oxycontin) 80 mg (#120) two tablets b.i.d. and replaced it with oxycodone HCL (Oxycontin) 30 mg (#360) 3 tablets q.i.d. (morphine equivalency dosage of 540 mg per day). Respondent also issued a new physical therapy order.[16] There was no explanation for the medication changes. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists (apart from the reference to a PT order), imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

51. On or about November 12, 2010, respondent had an office visit with patient W.B. to follow-up on alleged chronic pain, depression and anxiety-hyperactivity. Respondent never referred, or sought any consultation, for patient W.B.'s depression, anxiety and/or hyperactivity. There was no further mention of any physical therapy. The note for this visit indicates "fairly stable - not much help with oxycodone will try back on methadone 10 mg (#210) 7 per day" (morphine equivalency dosage of 840 mg per day). Respondent also continued the methylphenidate (Ritalin). Respondent subsequently indicated that he was maintaining patient W.B. on methadone because of patient W.B.'s history of heroin abuse, even though he was not an approved methadone provider for treating addiction. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding

[16] There is no indication in the records as to whether there was any subsequent physical therapy by patient W.B.

the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

52. On or about December 14, 2010, respondent had an office visit with patient W.B. to follow-up on alleged chronic pain with a note appearing to indicate "had good last month." Respondent issued a prescription for methadone HCL 10 mg (#150) 5 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 660 mg per day). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

53. On or about January 14, 2011, respondent had an office visit with patient W.B. The purpose of the visit is not clear from the note for this visit. The note indicates "had good 2 months" and appears to indicate "less headaches" and "more creative opportunity." Patient W.B.'s weight is listed as 192. Respondent issued prescriptions for methadone HCL 10 mg (#150) 5 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 660 mg per day) and methylphenidate (Ritalin) 20 mg (#90) b.i.d.[17] Respondent requested labs on this date. There was no detailed justification for re-starting the methadone HCL or methylphenidate (Ritalin). The note for this visit is cursory. A physical

[17] Respondent's chart note for this visit indicates the patient was prescribed 90 tablets of methylphenidate (Ritalin) while the CURES report indicates the patient filled a prescription for 270 tablets on February 7, 2011. Respondent also maintained a handwritten log of some of the controlled substances that were prescribed but there is no entry for January 14, 2011.

examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

54. On or about January 20, 2011, respondent faxed in a prescription for zolpidem tartrate (Ambien) 10 mg (#90) 1 tab p.r.n. (as needed) for sleep. There was no separate chart note for this prescription.

55. On or about January 14, 2011, respondent had a phone consultation with patient W.B. to follow up on "job reports." The note for this visit indicates the results of the prior lab testing and states "send lab reports" but there is no indication of where the lab reports were being sent. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

56. On or about February 5, 2011, respondent received a fax from medcohealth indicating that patient W.B. reportedly lost the zolpidem tartrate (Ambien) 10 mg (#90) that had been shipped to him and requested "your authorization to release an early refill for this medication" and verification "that this prescription is acceptable for us to dispense to the patient." Respondent approved the early refill by signing the form and faxing it back to medcohealth the next day.

////

57. On or about February 24, 2011, patient W.B. had a pain management consultation with a Dr. J.G.V. The History of Present Illness for this visit indicated the following:

> "[W.B.] presents complaining of neck pain, mid back pain, and low back pain. His pain scale is 2/10 to 7/10. He states that he is no longer using hydromorphone but rather has been using methadone 10 mg five tablets every 24 hours. He is requesting a refill of his methadone. The reasoning for this request is he states he has been using narcotics including abusing heroin in the past. He has been using narcotics for 30 years and has also abused heroin in the past. He denies upper or lower extremity numbness, tingling, pain or weakness. He denies any bladder or bowel incontinence. He states that he has not had time to have his lumbar spine MRI which was ordered in September 2010."

Patient W.B. falsely stated that he was "no longer using hydromorphone."[18] The physical examination of patient W.B. indicated intact neck, intact neurologic, and minimal spasms bilaterally - thoracolumbar for the musculoskeletal examination. The assessment/plan for this visit indicated, among other things, mild C5-C6 disc bulge with the following notation:

> "Mild C5-C6 Disc Bulge: There is no associated stenosis of the central canal or foramen on the MRI. His physical examination is negative. In the cervical spine, I do not see any objective findings to justify methadone 10 mg five times a day. I told him that I cannot assume the responsibility of refilling his narcotics when there are no objective findings to justify their use. He states that he needs to have narcotics because he has been using it for 30 years and that in the past he also abused heroin. I told [him] that this is not a reason to be prescribed narcotics but rather there needs to be objective findings to justify it."

According to the pain consultation note, patient W.B. was offered Suboxone therapy for opioid dependence but declined and indicated that he had not had time for a lumbar spine MRI to assess his alleged low back pain. Patient W.B. was referred out for further lab studies. Part of the plan included referral to a Dr. R.W. for pain management consultation since Dr. J.G.V. was not willing to prescribe methadone to patient W.B. Respondent was provided with a copy of the consultation note for this visit.

58. On or about April 19, 2011, respondent had an office visit with patient W.B. The purpose of the visit is not clear from the note for this visit. There is a notation indicating "need referral" but no further indication as to what the nature of the referral was for, what type of

---

[18] In truth and fact, patient W.B. had been receiving near monthly prescriptions from respondent for hydromorphone HCL and had filled a prescription for 150 tablets on January 21, 2011, that was prescribed by respondent approximately one week earlier.

specialist the referral related to, or who was seeking the referral. Despite the pain management consultation which indicated there was no objective basis for prescribing patient W.B. his opioid controlled substances, respondent issued prescriptions for methadone HCL 10 mg (#90) 3 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 400 mg per day). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, specifics regarding the pain management consult with Dr. J.G.V. of February 24, 2011, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

59. On or about May 13, 2011, respondent had a phone consultation with patient W.B. to "F/U" [follow-up] yet there is no specific indication on what respondent was following up on. The note for this visit indicates patient W.B. was doing well (or feeling well) and makes reference to carisoprodol (Soma) 350 mg 1 tab b.i.d. (#60) as needed for muscle spasms yet there is no further detailed discussion about the Soma in the chart note for his visit. Despite the recent pain management consultation which indicated there was no objective basis for prescribing patient W.B. his opioid controlled substances, respondent issued prescriptions for methadone HCL 10 mg (#90) 3 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 400 mg per day). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or

measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

60. During the period of on June 13, 2011, to on or about August 17, 2011, respondent had three phone consultations with patient W.B. During this time, respondent issued monthly prescriptions for methadone HCL 10 mg (#90) 3 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 400 mg per day) and also issued a prescription for methylphenidate (Ritalin) 20 mg (#90) 1/2 tablet b.i.d. The notes for the patient contacts during this time frame are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

61. During the period of on or about September 14, 2011, to on or about January 13, 2012, respondent had near monthly contact with Patient W.B. through phone consultations and/or an office visit. During this time, respondent issued monthly prescriptions for hydromorphone HCL (Dilaudid) 8 mg (#300) 2 tabs q (every) 4 hours p.r.n. pain (morphine equivalency dosage of 320 mg per day) There was no indication why respondent increased the dosage of the hydromorphone HCL (Dilaudid). The notes for the patient contacts during this time frame are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to

monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

62. On or about February 13, 2012, respondent saw patient W.B. for a follow up on "chronic pain syndrome." The note for this visit also indicated anxiety, depression, hepatitis C, allergies and hives. Respondent indicated in his note that he was decreasing the hydromorphone HCL (Dilaudid) and resuming methadone HCL. Respondent issued prescriptions for methadone HCL 10 mg (#90) 3 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 400 mg per day). The notes for the patient contacts during this time frame are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

63. On or about March 16, 2012, respondent had a phone consult with patient W.B. to follow up on "chronic pain syndrome." Respondent continued to suffer from anxiety and depression. Respondent issued prescriptions for methadone HCL 10 mg (#90) 3 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 400 mg per day). Respondent also issued a prescription for zolpidem tartrate (Ambien) 10 mg (#90) with no explanation as to why it was being prescribed. A lab request was made. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being

used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

64. On or about April 18, 2012, respondent had an office visit with patient W.B. in which his lab results were reviewed. Respondent issued prescriptions for methadone HCL 10 mg (#150) 5 tabs daily (morphine equivalency dosage of 500 mg per day), methylphenidate (Ritalin) 20 mg (#90) 1 tab b.i.d., and hydrocortisone 5 mg (#60) 1-2 tabs in the afternoon. There was no explanation for the increase in the methadone HCL. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

65. On or about May 11, 2012, respondent had an office visit with patient W.B. to follow up on respondent's "chronic pain." The note for this visit makes reference to, among other things, depression, Hep C and that patient W.B. "using Soma – needs refill" and "will use hydromorphone instead of methadone." Respondent issued prescriptions for hydromorphone HCL (Dilaudid) 8 mg (#300) 10 tabs daily (morphine equivalency dosage of 320 mg per day) and carisoprodol (Soma) 350 mg (#60) 1 tab b.i.d. There was no explanation for discontinuing the methadone HCL or prescribing the carisoprodol (Soma). Nor is there any indication who previously prescribed the carisoprodol (Soma) to patient W.B. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed

consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

66. On or about June 20, 2012, respondent had an office visit with patient W.B. to follow up on respondent's "chronic pain," depression and Hep C. The note for this visit indicates that respondent discussed lowering the dose of hydromorphone HCL and the methadone HCL that was just discontinued but there was no rationale documented for why he was lowering the dosages or starting patient W.B. back on the methadone HCL. Respondent issued prescriptions for methadone HCL 10 mg (#90) 3 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 1-2 tabs t.i.d. (combined morphine equivalency dosage of 400 mg per day). Even though respondent indicated he was lowering the dosages of the aforementioned opioids, he actually increased the morphine equivalency dosage from that of the prior visit. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

67. On or about August 29, 2012, respondent had a phone consult with patient W.B. to follow up on patient W.B.'s "chronic pain," depression and Hep C. Respondent issued prescriptions for methadone HCL 10 mg (#90) 3 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#150) 5 per day (combined morphine equivalency dosage of 400 mg per day) and zolpidem tartrate (Ambien) 10 mg (#90) 1 tab per day (three month supply). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or

current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

68. On or about October 3, 2012, respondent had a phone consult with patient W.B. to follow up on respondent's "chronic pain syndrome" and Hep C. The note for this visit indicates "balanced treatment program – doing well." Respondent issued prescriptions for methadone HCL 10 mg (#120) 4 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#120) 4 tabs per day and (combined morphine equivalency dosage of 448 mg per day). There was no rationale for increasing the methadone HCL from 3 to 4 tabs daily. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

69. On or about November 28, 2012, respondent had an office visit with patient W.B. to follow up on respondent's "chronic pain syndrome" and Hep C. The note for this visit appears to indicate "meds working out last month" and needs Ritalin refilled. Respondent issued prescriptions for methadone HCL 10 mg (#120) 4 tabs daily, hydromorphone HCL (Dilaudid) 8 mg (#120) 4 tabs per day and (combined morphine equivalency dosage of 448 mg per day) and methylphenidate (Ritalin) 20 mg (#180) 1 tab b.i.d. There is no rationale regarding the need for the methylphenidate (Ritalin) prescription. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital

signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

70. During the period of on or about December 24, 2012, to November 23, 2015, respondent continued to have office visits or phone consults on a near monthly basis for patient W.B.'s primary medical conditions which, according to the chart notes, were listed as chronic pain syndrome and hepatitis C. During this period of time, patient W.B. was issued prescriptions, and maintained on, methadone HCL 10 mg (#120) 4 tabs daily and hydromorphone HCL (Dilaudid) 8 mg (#120) 4 tabs per day (combined morphine equivalency dosage of 448 mg per day). During this period of time, respondent also refilled patient W.B.'s prescriptions for methylphenidate (Ritalin) 20 mg (#180) 1 tab b.i.d. (three month supply) approximately every three months;[19] and zolpidem tartrate (Ambien) 10 mg (#90) 1 tab per day 9 (three month supply) approximately every three months. The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, imaging or other objective testing, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient W.B. was not diverting controlled substances or taking additional controlled substances.

////

[19] The CURES report for patient W.B. indicates that patient W.B. obtained 420 tablets of methylphenidate (Ritalin) between on or about March 14, 2014, and April 17, 2014.

71. Respondent committed gross negligence in his care and treatment of patient W.B., which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient W.B. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient W.B. without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

////

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. despite indications of addiction and ignored the findings of the pain management consultant of February 24, 2011;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. which exceeded the generally accepted maximum daily dosages for opioids which increased the risk of harm to patient W.B.;

(h) Respondent failed to properly evaluate and manage patient W.B.'s alleged chronic pain and elevated blood pressure; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient W.B. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

PATIENT C.B.

72. On or about December 5, 2008, respondent began treating patient C.B., a then 62-year old male, with a history of self reported "numerous injuries" from a "taxing (physical) occupation." Patient C.B. reported, among other things, that he had prior surgeries to his hand, right arm, hip, knees and nose; he was taking hydromorphone, clonidine (used to treat high blood pressure) and temazepam (used for insomnia); and that his "health condition causes anxiety." At this visit, patient C.B.'s vital signs were recorded as 150/100, heart with normal sinus rhythm, lungs clear, oxygen saturation 98% and pulse 75. Respondent recorded that patient C.B. used a cane. Apart from the information on patient C.B.'s "Patient Registration Form," there was no further history, no targeted physical exam, no location indicated for any pain, no pain scale, no clarifying prior medical history questions by respondent, and no mention of patient C.B.'s elevated blood pressure. Patient C.B. was provided with a "Mutual Opioid Treatment Agreement" that both he and respondent signed. Respondent did not periodically review the pain contract with patient C.B. nor was it discussed in detail. Respondent issued a prescription for hydromorphone HCL (hydrochloride) 8 mg (#360) 3 tablets q.i.d. (morphine equivalency dosage of 384 mg). Respondent's note for this visit is cursory and there was no documentation concerning, among other things, past imaging and/or testing, past referrals and/or consultation

with other specialists, informed consent on the risks of opiate use or other possible alternatives to opioids, and no detailed management plan for the patient.

73. On or about December 6, 2008, to on or about July 12, 2009, respondent had contact with patient C.B. on a near monthly basis through either phone consults or office visits. During this period of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg that was generally titrated up from (#360) 3 tabs q.i.d. per month (morphine equivalency does of 384) to (#480) 4 tabs q.i.d. per month (morphine equivalency does of 512). During this time frame, respondent also issued prescriptions on January 5, 2009, and June 22, 2009, for morphine sulfate (MS Contin) 100 mg (#20) (morphine equivalency dosage of 100 mg)[20]; and diazepam[21] 10 mg (#30 or #50)[22] one-half tab to 1 tab on February 24, 2009 and March 11, 2009.

74. On or about July 13, 2009, respondent had a phone consult with patient C.B. in which he indicated he was drinking more alcohol (even though he had previously indicated at his initial visit that he did not drink alcohol) with the chart note indicating "anger." The note for the visit indicates, among other things, discontinue beer and ten day cleanse.

75. During on or about July 14, 2009, through on or about February 15, 2010, respondent had contact with patient C.B. on a near monthly basis through one office visit on July 22, 2009, and then phone consults for each month thereafter, in regards to the patient's alleged "chronic pain syndrome" and other health issues. On or about July 22, 2009, respondent filled out a County of San Diego Health and Human Services Agency form for patient C.B., in regard to an In-Home Supportive Services evaluation, which listed, among other things, diagnoses of chronic pain syndrome, multiple skeletal injuries, and chronic narcotic use. Respondent also noted on the form that patient C.B. had, on occasion, "overused meds like Valium and alcohol." During this

---

[20] The addition of the morphine sulfate (MS Contin) to the equation increased the extremely high morphine equivalency dosage another 100 milligrams.

[21] Diazepam (Valium) s a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat anxiety.

[22] Respondent's notes appear to indicate 50 tabs while the CURES report and an authorization form indicate 30 tabs.

period of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#480) 3-4 tabs q.i.d. (morphine equivalency dosage of 512 mg). The chart notes during this period of time are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain levels, location of any pain, and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled substances or taking additional controlled substances.

76. On or about February 16, 2010, respondent had a phone consult with patient C.B. to follow up on his "chronic pain syndrome." The note for this visit indicates "worries about med[ication] stock." Respondent increased the patient's prescription to hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 4 t.i.d. (morphine equivalency dosage of 544 mg). The chart notes for this visit is cursory. No physical examination was performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain levels, location of any pain, and/or functional abilities. In addition, there was no documentation concerning, among other things, why the hydromorphone HCL prescription was being titrated up, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances

77. During on or about February 17, 2010, to on or about May 22, 2011, respondent had contact with patient C.B. on a near monthly basis through two office visits on July 6, 2010, and August 5, 2010, and phone consults, for the other months, in regard to the patient's alleged "chronic pain syndrome" and other health issues. Patient C.B. had hand surgery at some time in April 2011 with partial amputation of the distal right third and fourth digits. During this period

of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 4 t.i.d. (morphine equivalency dosage of 544 mg). The chart notes for the patient encounters by phone or office visit are cursory. No physicals were performed or documented (with the exception of a minimal examination on August 5, 2010) and respondent failed to document or obtain vital signs, past medical history (apart from the hand surgery), past or current alcohol or drug use or abuse, pain levels, location of any pain (with the exception of a references to patient C.B.'s "hand flaring"), and/or functional abilities. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists (besides a general reference to patient C.B.'s hand surgery), the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

78. On or about May 23, 2011, to on or about September 18, 2011, respondent had contact with patient C.B. through phone consults in regard to the patient's alleged "chronic pain syndrome" and other health issues. During this period of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#420) 5 tabs in the morning and 3 tabs t.i.d. (morphine equivalency dosage of 448 mg). The chart notes during this period of time are cursory. There was no justification provided for titrating down the hydromorphoneHCL. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain levels (except for July 15, 2011 [pain level of 4-5 out of 10]), location of any pain, and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

79. On or about September 19, 2011, respondent had a phone consult with patient C.B. where he followed up on patient C.B.'s "chronic pain,". The note for this visit indicates

"multiple bone and joint injuries, exams rigidity of spine, flexion of 65%, deformities of bilateral hand joints due to arthritis, limited grip strength, neck tender with LOM (loss of motion) all directions." The diagnosis was D.J.D. (degenerative joint disease) multiple joints and chronic pain syndrome. Respondent recommended to get a power mobility device and filled out the necessary forms, including a power mobility device evaluation form, in which respondent indicated, among other things, that patient C.B. had moderate upper body weakness, moderate upper body pain, partially limited upper body range of motion, severe lower body pain and partially limited lower body range of motion. Respondent issued a prescription for hydromorphone HCL 8 mg (#420) 5 tabs in the morning and 3 tabs t.i.d. (morphine equivalency dosage of 448 mg). There was no physical examination and respondent failed to document or obtain vital signs, past medical history, and past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

80. During the period of on or about September 20, 2011, to on or about January 30, 2012, respondent had near monthly contact with patient C.B. through phone consults and one office visit of October 28, 2011. During this period of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#420) 5 tabs in the morning and 3 tabs t.i.d. (morphine equivalency dosage of 448 mg). The chart notes during this period of time are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs (except for October 28, 2011, indicating blood pressure 176/104 [that was not addressed by respondent] and pulse of 56), past medical history, past or current alcohol or drug use or abuse, pain levels (except for October 28, 2011 [indicating pain level of "3-4 controlled"]) and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating

periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

81. On or about February 1, 2012, through July 31, 2012, respondent had contact with patient C.B. on a near monthly basis through phone consults for follow up on his diagnoses of chronic pain and degenerative joint disease and other health issues. During this period of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 3 tabs q.i.d. (morphine equivalency dosage of 544 mg). The pain level for February 1, 2012, was listed as 3-4 (which was the same pain level recorded on November 10, 2011), and there was no detailed justification documented as to why respondent titrated up the dosage of the hydromorphone HCL apart from a note in the chart indicating "cold weather makes joints worse." The notes during this period of time are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain levels (except for February 1, 2012 [pain 3-4], and July 2, 2012 [pain level 6]), location of any pain, and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists (except for a notation on July 2, 2012, to "check with hand surgeon"[23] and "also need GI endoscopy"), the risks of opiate use and/or other controlled substances, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

82. On or about August 1, 2012, respondent performed a physical examination on patient C.B. in regards to obtaining a power assisted mobility device. This physical examination was the only comprehensive examination done by respondent during the time he saw patient C.B. The note for this visit indicated among other things, pain levels (between 7 to 9 out of 10) and locations of pain, range of motion limitations, vital signs, and diagnoses of degenerative joint disease, chronic pain, and that patient C.B.'s condition had an impact on his activities of daily

[23] The note for July 2, 2012, states, in pertinent part "hand bothering check with hand surgeon." The note contains no more specifics concerning patient C.B.'s hand.

living. Patient C.B. had an elevated blood pressure of 180/100 that was not addressed by respondent. As part of this visit, respondent refilled patient C.B.'s prescription for hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 3 tabs q.i.d. (morphine equivalency dosage of 544 mg). During this visit, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use and/or other controlled substances, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances. This was the last office visit that respondent had with patient C.B. and all remaining contacts with patient C.B. were phone contacts.

83. During the remainder of 2012, from on or about August 2, 2012, to December 31, 2012, respondent had contact with patient C.B. on a near monthly basis through phone consults for follow up on his diagnoses of chronic pain and degenerative joint disease and other health issues. During this period of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 3 tabs q.i.d. (morphine equivalency dosage of 544 mg). The chart notes during this period of time are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain levels and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

84. During 2013, respondent had contact with patient C.B. on a near monthly basis through phone consults on January 28, February 22 [or 27], March 21, April 20, May 28, June 28, August 2, 2013, for follow up on patient C.B.'s diagnoses, other health issues, and/or for

medication refills.[24] On or about May 7, 2013, Walgreen's Pharmacy requested "a diagnosis code and/or medical justification" for patient's C.B.'s hydromorphone prescription. Respondent faxed back a note indicating "Chronic pain syndrome due to multiple traumatic injuries – known narcotic user for years on disability" and indicated an ICD-9 code of 338.14 (chronic pain syndrome). (Emphasis in original.) During this period of time, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 3 tabs q.i.d. (morphine equivalency dosage of 544 mg). The chart notes during this period of time are cursory.[25] Physical examinations were not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

85. During 2014, respondent had contact with patient CB through near monthly phone consults[26] to follow up on his diagnoses, other health issues, and/or for medication refills. On or about March 5, 2014, respondent sent a facsimile to CVS Caremark which stated the following:

> "I began treating Mr. [C.B.] on December 5, 2008, as a new patient for me. He has a long history of narcotic usage to control pain from multiple injuries while working on the railroads. He was Hydromorphone 8 mg tablets when I first saw him. He had evidently used other pain meds previously. He is a registered narcotic user, for severe degenerative joint disease in multiple areas. Any change in medication would produce withdrawal reactions. See copies of medical reports."

---

[24] Due to the brief and cursory nature of respondent's chart notes, it's not clear whether respondent actually spoke with patient C.B. for each date listed in the chart notes; or if some of the notes were just to indicate medication refills.

[25] Respondent's chart notes for 2013 consist of handwritten notes, that are difficult to decipher, which cumulatively fit on a single sheet of paper. Any statements about respondent's condition are brief and conclusory with no mention of any targeted physical examinations and/or objective testing or imaging.

[26] Respondent's chart notes for 2014 indicate the following dates: February 3, March 5, April 2, May 2, May 19, June 30, July 30, September 3, October 1, October 31, November 24, and December 19, 2014.

During 2014, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 3 tabs q.i.d. (morphine equivalency dosage of 544 mg). The chart notes during this period of time are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain level (except for May 19, 2014 [pain level of 3-4 with no location indicated] and October 31, 2014 [pain level of 4-5 with no location indicated]) and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

86. During 2015, respondent had contact with patient C.B. through near monthly phone consults[27] to follow up on his diagnoses of chronic pain and degenerative joint disease, other health issues, and/or for medication refills. During 2015, respondent maintained patient C.B. on hydromorphone HCL 8 mg (#510) 5 tabs in the morning and 3 tabs q.i.d. (morphine equivalency dosage of 544 mg). Respondent also issued prescriptions for temazepam 30 mg (#30) 1 tab daily on September 16, 2015 and October 19, 2015.[28] The chart notes during this period of time are cursory. Physical examinations were not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse, pain level (except for April 24, 2015 [pain level of 3-4 with no location indicated] and November 18, 2015 [pain level of 4-5 with no location indicated]) and/or functional abilities. In addition, there was no documentation concerning, among other things, past imaging and/or testing, referrals and/or consultation with other specialists, the risks of opiate use, any detailed

[27] Respondent's chart notes for 2015 indicate the following dates: January 21, February 23, March 27, April 24, May 27, June 29, July 22, July 29, August 17, September 16, October 19, November 18 and December 14, 2015.

[28] Temazepam (Restoril®), a benzodiazepine, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for patients with short term insomnia.

management plan for the patient and/or any documentation indicating periodic drug screening, efforts to monitor compliance and/or measures to ensure patient C.B. was not diverting controlled substances or taking additional controlled substances.

87. Respondent committed gross negligence in his care and treatment of patient C.B., which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient C.B. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs and pain scales, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging and/or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient C.B. without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

////

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. despite indications of abuse and/or addition to the narcotics and controlled substances that were being prescribed;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. which exceeded the generally accepted maximum daily dosages for opioids which increased the risk of harm to patient C.B.;

(h) Respondent failed to properly evaluate and manage patient C.B.'s alleged chronic pain and elevated blood pressure; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient C.B. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

PATIENT M.O.

88. On or about July 12, 2010, respondent began treating patient M.O, a then 21-year old male, with a self-reported history of Attention Deficit Hyperactivity Disorder (ADHD) and anxiety. According to respondent, patient M.O. had a troubled history and had been sodomized by his father and an uncle from ages 5 through 7, and was now "staying with [an] adult mentor," one of respondent's other patient's, who was assisting patient M.O., and providing guidance to him. Patient M.O. was trying to return to community college to obtain some college credits. As part of his history, patient M.O. failed to fill out the section of the his Patient Registration Form and a Metabolic Assessment Form related to alcohol usage and there were no follow up questions by respondent regarding alcohol usage. At this initial visit, respondent obtained vital signs and the only physical examination was of the heart and lungs with a notation that his heart had NSR (normal sinus rhythm) with no murmurs and the lungs were clear. A pain level of zero was obtained. Respondent's note indicated patient M.O. had "some court stress" without any

additional explanation. Respondent's file for patient M.O. contains a Mutual Opioid Agreement dated July 2, 2010, that was signed by respondent and patient M.O. Respondent did not periodically review the pain contract with patient M.O. nor was it discussed in detail. On this visit, respondent issued a prescription of amphetamine salts (Adderall)[29] 20 mg (#180) 2-3 tabs b.i.d. (twice a day). Respondent did not provide a referral to a mental health provider at this visit or at any other time. In regard to the Adderall prescription, respondent took no steps to confirm whether patient M.O. had, in fact, previously been on Adderall at any time. There was no documentation concerning, among other things, the risks of opiate use, any detailed management plan for the patient and/or any documentation indicating any drug screening or CURES review prior to prescribing the Adderall.

89. On or about August 30, 2010, respondent had a visit with patient M.O. to follow up on the diagnosis of ADHD. The note for this visit indicates, among other things, "good results with 60-80 mg Adderall" and "had used Xanax before sleeping..." Respondent issued a prescription for amphetamine salts (Adderall) 20 mg (#180) 2-3 tabs b.i.d. and added a prescription for alprazolam (Xanax)[30] 1 mg (#120) 1 tab q.i.d. (four times a day). In regard to the new alprazolam prescription, respondent took no steps to confirm whether patient M.O. had, in fact, previously been on alprazolam (Xanax) at any time. The chart note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the risks of the controlled substances

---

[29] Adderall® is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.)

[30] Alprazolam (Xanax®), a benzodiazepine, is considered a drug of abuse by the DEA. According to the DEA, "abuse is frequently associated with adolescents and young adults who take the drug orally or crush it up and snort it to get high." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 53.)

being used or prescribed, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

90. On or about September 24, 2010, respondent had an office visit with patient M.O. wherein he tested for any sexually transmitted diseases (STD's) with a negative test result. On this visit, respondent prescribed amphetamine salts (Adderall) 20 mg (#180) 2-3 tabs b.i.d. and added a prescription for diazepam (Valium) 5 mg (#90) 1 tab t.i.d. The chart note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the risks of the controlled substances being used or prescribed, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

91. On or about November 12, 2010, respondent had an office visit with patient M.O. in which respondent issued prescriptions for amphetamine salts (Adderall) 20 mg (#180) 2-3 tabs b.i.d. and added a prescription for diazepam (Valium) 5 mg (#90) 1 tab t.i.d. The chart note for this visit is cursory.[31] A physical examination was not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the risks of the controlled substances being used or prescribed, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or

[31] In fact, the only information for this visit is respondent's handwritten notes about the two prescriptions he issued on November 12, 2010. This is set forth on approximately one-quarter of a page that includes handwritten notes regarding four other dates.

measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

92. On or about December 23, 2010, respondent had a visit with patient M.O. concerning a possible shoulder fracture and torn rotator cuff. No imaging was obtained despite the possible shoulder fracture or torn rotator cuff. As part of this visit, respondent prescribed oxycodone HCL APAP (Percocet)[32] 7.5/500 mg (#40) 1 tab every 4 hours. The chart note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the risks of the controlled substances being used or prescribed, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

93. On or about January 7, 2011, respondent issued another prescription for oxycodone HCL APAP (Percocet) 7.5/500 mg (#40) 1 tab every 4 hours. The note for this visit indicates "last refill must see orthopedic for refill." The chart note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs, past medical history, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

94. On or about June 6, 2011, respondent had an office visit with patient M.O. and assessed him with bipolar disorder and depression with "symptomatic [increase of] alcohol."

[32] Percocet® is a brand name for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat moderate to moderately severe pain.

Vital signs were taken for this visit which indicated blood pressure of 145/93 and pulse of 82. The elevated blood pressure of 145/93 was not further evaluated or addressed by respondent. Despite the new assessment of bipolar disorder, combined with the prior diagnoses of ADHD and anxiety, respondent did not refer out, or seek, a mental health consultation. Respondent issued prescriptions for Depakote 250 mg (#90) 1 tab t.i.d. with 2 refills; alprazolam (Xanax) 1 mg (#100) 1 tab 3-4 times daily; and some other illegible medication. The chart note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain past medical history, information regarding past alcohol or drug abuse or specifics regarding current alcohol[33] or drug use or abuse. In addition, there was no documentation concerning, among other things, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

95. On or about June 24, 2011, respondent had an office visit with patient M.O. to follow up on increased anxiety, "some paranoia," and patient M.O. "not sleeping." Vital signs were taken for this visit which indicated blood pressure of 145/95 and pulse of 80. Despite an increase in anxiety, a new symptom of paranoia, patient M.O. "not sleeping" and the prior assessment of bipolar disorder[34] and depression, respondent did not refer out to, or seek consultation with, a mental health specialist at this time or at any other time during his treatment of patient M.O. Respondent issued a prescription for zolpidem tartrate (Ambien) 10 mg (#30) 1 tab a day and patient M.O. refilled his prescription for alprazolam (Xanax) 2 mg (#120) 1 tab 3-4 times daily. The note for this visit also indicates a prescription for Seroquel XR[35] which, according to

---

[33] While respondent indicated "symptomatic [increase of] alcohol" there was no information obtained or documented regarding any prior drinking pattern or usage or the current drinking pattern or usage by patient M.O.

[34] During his physician interview, respondent was asked how many patients he typically treated with bipolar disorder in a month, if any, and respondent answered "maybe I would have to say none in a month."

[35] Seroquel XR (quetiapine) is an oral antipsychotic drug prescribed for the treatment of (continued...)

respondent, was never used because it was too expensive. The chart note for this visit is cursory and difficult to decipher. A physical examination was not performed or documented; and respondent did not document past medical history, information regarding past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

96. On or about June 30, 2011, respondent had a phone consult with patient M.O. who indicated he was unable to sleep with just one tab of Ambien and that patient M.O. would take a second Ambien 45 minutes later and "gets good sleep." For this visit, respondent recorded a pain level of 0, depression – mild; social activities – school and no side effects. Respondent also noted that patient M.O. "felt rested" and his Xanax usage was decreased using another medication (illegible on the chart note) and the previously prescribed Depakote. A physical examination was not performed or documented; and respondent did not document past medical history, information regarding past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

97. On or about July 12, 2011, respondent had an office visit with patient M.O. to follow up on medications and his bipolar disorder. Patient M.O. also complained of further swelling right groin for a month and burning anal pain right side for one week. The assessment was lymphadenitis (swelling or inflammation of the lymph notes). There is no management plan listed for the new complaints and no indication of any further evaluation. Respondent prescribed

---

(...continued)
schizophrenia and acute treatment of manic or mixed episodes associated with bipolar I disorder.

zolpidem tartrate (Ambien) 10 mg (#30) 2 tabs a day; alprazolam (Xanax) 2 mg (#120) ½ or 1 tab q.i.d. (4 times a day); and Depakote 250 mg (#90) 1 tab t.i.d. (3 times a day). The chart note for this visit is cursory and difficult to decipher. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

98. On or about July 28, 2011, respondent had an office visit with patient M.O. to follow up with the note for this visit indicating that patient M.O. "was in County Sheriff's Central Jail on July 16 – held briefly 12 hours."[36] The note for the visit contains no specifics as to why patient M.O. had been in jail. Respondent's right groin nodule was noted to be "same" and the patient's "anal area still inflamed." Respondent recommended an ointment for the inflammation. Respondent prescribed alprazolam (Xanax) 2 mg (#120) ½ or 1 tab q.i.d. (4 times a day). The chart note for this visit is cursory and difficult to decipher. A physical examination was not performed or documented (except for follow up and visual inspection of patient M.O.'s right groin nodule and anal area) and respondent failed to document or obtain vital signs; and did not document past medical history, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

---

[36] On July 17, 2011, respondent faxed a medical release so the San Diego Central Jail, Medical Services Unit, could obtain "medical records for [M.O.] in order to meet his needs while housed at San Diego Central. Jail."

99. On or about September 20, 2011, respondent had an office visit with patient M.O. who complained of pain in the right scapula and trapezius (right shoulder and upper back areas) with the pain listed as 6 out of 10. Respondent prescribed alprazolam (Xanax) 2 mg (#100) ½ or 1 tab q.i.d. (4 times a day) and carisoprodol (Soma) 350 mg (#90) 1 tab t.i.d. (three times a day). There was no specific explanation for adding the Soma and no indication of whether any other alternatives to the Soma were considered. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history (including, but not limited to, the status of patient M.O.'s past groin nodule or inflamed anal area), past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O.t was not diverting controlled substances or taking additional controlled substances.

100. On or about October 17, 2011, respondent had an office visit with patient M.O. who complained of increased pain in the left shoulder area – "post surgery trauma March 2011" with a notation that the patient was "to see surgeon soon." There is no prior reference to patient M.O.'s prior surgery.[37] Respondent prescribed and/or indicated that the patient was using alprazolam (Xanax) 2 mg (#100) ½ or 1 tab q.i.d. (4 times a day) and issued a new prescription of oxycodone HCL APAP (Percocet) 7.5/325 mg (#40) 1 tab every 4-6 hours as needed for pain. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists (except for the reference of "to see surgeon soon"), informed consent regarding the risks of the controlled substances being used, any detailed management

[37] The chart note for December 23, 2010, indicated a "torn rotator cuff" and a chart note for January 7, 2011, indicated that respondent would prescribe no more Percocet and the patient would have to see "orthopedic for refill." However, after this date, there were no chart notes indicating that patient M.O. had actually undergone any surgery.

plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

101. On or about November 3, 2011, respondent had an office visit with patient M.O. for what appears to be a medication follow-up. The reason for of the visit is not stated in the note for the visit. Respondent prescribed amphetamine salts (Adderall) 20 mg (#90) 1 tabs t.i.d (without any explanation as to why the Adderall was being restarted after approximately one year) and issued a refill for the oxycodone HCL APAP (Percocet) 7.5/325 mg (#40) 1 tab every 4-6 hours as needed for pain with another note that patient M.O. was "to see ortho surgeon soon." A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

102. On or about January 9, 2012, respondent had an office visit with patient M.O. for follow-up. The note indicates that patient M.O. felt "internal anxiety." Patient M.O's medications for this visit were listed as carisoprodol (Soma) 350 mg (#90) 1 tab t.i.d. (three times a day); zolpidem tartrate (Ambien) 10 mg (#30) 1 tab a day; and (Xanax) 1 mg (#100) ½ or 1 tab q.i.d. (4 times a day).[38] There was no explanation for restarting the Soma that was last prescribed by respondent on September 20, 2011. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other

[38] According to the CURES report, the prescriptions were all filled on February 16, 2012.

specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

103. During the period of on or about January 10 2012, to on our about May 1, 2012, patient M.O. filled prescriptions of alprazolam (Xanax) 1 mg (#100) twice; carisoprodol (Soma) 350 mg (#90) twice; and zolpidem tartrate (Ambien) once during this period of time.

104. On or about May 2, 2012, respondent had an office visit with patient M.O. for follow up on anxiety, stress and sleep problems. The note for this visit indicates respondent would substitute Valium for Xanax with no reason stated for the substitution. Respondent issued a prescription for diazepam (Valium) 10 mg (#120) 4 tabs a day and amphetamine salts (Adderall) 20 mg (#90) 1 tabs t.i.d. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

105. On or about June 26, 2012, respondent had an office visit with patient M.O. in which he followed up on anxiety and stress. According to the note for this visit, patient M.O. indicated that he liked Xanax better than Valium and his anxiety improved. Respondent prescribed amphetamine salts (Adderall) 20 mg (#60) 1 tabs a.m. and noon; alprazolam (Xanax) 1 mg (#90) 1 tab t.i.d.; flexeril (a muscle relaxant used to treat muscle pain) 10 mg (#90) every 4-6 hours for muscle spasms (with no specifics regarding the muscle spasms in the note for this visit); and trazadone (an antidepressant) 50 mg 1 or 2 tabs a day. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In

addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

106. During the period of on or about June 27, 2012, to on our about September 19, 2012, patient M.O. filled prescriptions of alprazolam (Xanax) 1 mg (#100) three times; amphetamine salts (Adderall) 20 mg (#60) once; diazepam (Valium) 10 mg (#120) twice (despite the fact that patient M.O. had indicated he "liked Xanax better than Valium"); oxycodone HCL APAP (Percocet) 7.5/500 mg (#30) once; and zolpidem tartrate (Ambien) 10 mg (#30) once.

107. On or about September 20, 2012, respondent had a follow up office visit with patient M.O. The note for this visit indicates, among other things, that patient M.O. was having increased anxiety and not sleeping. Respondent refilled prescriptions for amphetamine salts (Adderall) 20 mg (#60) 1 tabs a.m. and noon; alprazolam (Xanax) 1 mg (#90) 1 tab t.i.d.; and Lunesta[39] (eszopiclone) 2 mg (#60) 1 or 2 tabs a day as needed for sleep. The note for this visit is cursory and difficult to decipher. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

108. On or about November 9, 2012, respondent had an office visit with patient M.O. The note for this visit indicates "finishing court ordered public service" (with no additional details of

[39] Lunesta, a sedative, is a brand name for eszopiclone, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat insomnia.

what led to the court ordered public service) and not sleeping with Ambien and will try Temazepam 30 mg (#30). Respondent refilled prescriptions for alprazolam (Xanax) 2 mg (#90); (Adderall) 20 mg (#90) (with no indication of why he was increasing from 60 to 90 tablets); and carisoprodol (Soma) 350 mg (#120) 1 tab 4 times a day (with no indication of why the Soma was being prescribed). The note for this visit is cursory. A physical examination was not performed or documented and respondent failed to document or obtain vital signs; and did not document past medical history, pain level, past or current alcohol or drug use or abuse. In addition, there was no documentation concerning, among other things, referrals and/or consultation with other specialists, informed consent regarding the risks of the controlled substances being used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure respondent was not diverting controlled substances or taking additional controlled substances. This was the last office visit that respondent had with patient M.O.[40]

109. During the period of on or about November 10, 2012, to on or about August 23, 2013, approximately nine and one-half months, respondent continued to prescribe various controlled substances that were filled by patient M.O. over this period of time without any office visits or phone consults and little, if any, medical documentation. Specifically, during this period of time, patient M.O. filled ten prescriptions for alprazolam (Xanax) 2 mg (8 for #90 and 2 for #100); nine prescriptions of amphetamine salts (Adderall) 20 mg (#90); ten prescriptions of carisoprodol (Soma) 350 mg (#120); eight prescriptions of diazepam (Valium) 10 mg (#60) beginning on January 15, 2013; one prescription of hydrocodone APAP 7.5/325 mg (#20); temazepam 30 mg (#30) on November 12, 2012; and eight prescriptions of zolpidem tartrate (Ambien) 10 mg (seven for #30 and one for #60). During this period of time, there were no office visits, inadequate documentation, physical examinations were not performed or documented and respondent failed to document or obtain vital signs; and there was no documentation of any past medical history,

[40] Respondent indicated in his physician interview that September 20, 2012, was his last office visit with patient M.O. However, his note for November 9, 2012, indicates "OV" which was respondent's abbreviation for an office visit.

pain level, past or current alcohol or drug use or abuse, referrals and/or consultation with other specialists, objective testing performed, lab tests run, informed consent regarding the risks of the controlled substances being prescribed and used, any detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure patient M.O. was not diverting controlled substances or taking additional controlled substances.

110. Respondent committed gross negligence in his care and treatment of patient M.O., which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient M.O. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs and pain scales, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging and/or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient M.O. without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. despite indications of abuse and/or addition to the narcotics and controlled substances that were being prescribed;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. which exceeded the generally accepted maximum daily dosages for amphetamine salts (Adderall) which increased the risk of harm to patient M.O.;

(h) Respondent failed to adequately address respondent's elevated blood pressure; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient M.O. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

111. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in her care and treatment of patients C.D., W.B., C.B. and M.O., as more particularly alleged in paragraphs 16 through 110, above, which are hereby incorporated by reference and realleged as if fully set forth herein. The repeated negligent acts includ, but are not limited to the following:

////

////

////

PATIENT C.D.

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient C.D. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient C.D. without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care;

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. despite indications of addiction, without close consultation with an addiction medicine specialist;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient C.D. which exceeded generally accepted maximum daily dosages for alprazolam (Xanax) and acetaminophen which increased the risk of harm to patient C.D.;

(h) Respondent failed to properly evaluate and manage patient C.D.'s alleged anxiety, attention deficit and hyperactivity disorder (ADHD) and chronic pain; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient C.D. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

PATIENT W.B.

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient W.B. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient W.B. without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the

possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. despite indications of addiction and ignored the findings of the pain management consultant of February 24, 2011;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient W.B. which exceeded the generally accepted maximum daily dosages for opioids which increased the risk of harm to patient W.B.;

(h) Respondent failed to properly evaluate and manage patient W.B.'s alleged chronic pain and elevated blood pressure; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient W.B. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

PATIENT C.B.

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient C.B. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs and pain scales, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging and/or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient C.B.

without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. despite indications of abuse and/or addition to the narcotics and controlled substances that were being prescribed;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient C.B. which exceeded the generally accepted maximum daily dosages for opioids which increased the risk of harm to patient C.B.;

(h) Respondent failed to properly evaluate and manage patient C.B.'s alleged chronic pain and elevated blood pressure; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient C.B. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

PATIENT M.O.

(a) Respondent repeatedly prescribed narcotics and controlled substances, to patient M.O. without obtaining an adequate history and without performing appropriate physical examinations including, but not limited to, obtaining a detailed history in regard to physical and/or mental health, consistently obtaining vital signs and pain scales, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, obtaining imaging and/or other objective testing, and, thus, repeatedly prescribed narcotics and controlled substances to patient M.O. without adequate justification;

(b) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without adequate monitoring and without discussing and/or clearly documenting an adequate treatment plan and/or functional goals with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialist or specialists;

(e) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. without reviewing CURES, without utilizing urine drug screens, without consulting with and/or obtaining records from prior treating physicians and/or other risk screening tools;

////

////

(f) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. despite indications of abuse and/or addition to the narcotics and controlled substances that were being prescribed;

(g) Respondent repeatedly prescribed narcotics and controlled substances to patient M.O. which exceeded the generally accepted maximum daily dosages for amphetamine salts (Adderall) which increased the risk of harm to patient M.O.;

(h) Respondent failed to adequately address respondent's elevated blood pressure; and

(i) Respondent failed to maintain adequate and accurate records in regard to his care and treatment of patient M.O. The records lacked adequate detail and specificity and were often illegible and/or difficult to decipher.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

112. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated incompetence in the care and treatment of patient C.D., W.B., C.B. and M.O., as more particularly alleged in paragraphs 16 through 111, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs Without Conducting an Appropriate Prior Examination and Medical Indication)

113 Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that Respondent prescribed dangerous drugs to C.D., W.B., C.B. and M.O., without an appropriate prior examination and medical indication, as more particularly alleged in paragraphs 16 through 111, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

////

////

FIFTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

114. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing drugs or treatment to patients C.D., W.B., C.B. and M.O., as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 16 through 111, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Furnishing Drugs To Addict)

115. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2241 of the Code, in that respondent prescribed controlled substances and dangerous drugs to patients C.D., W.B., C.B. and M.O., whom he knew or reasonably should have known was an addict and/or was using or would be using the controlled substances and dangerous drugs for a nonmedical purpose, as more particularly alleged in paragraphs 16 through 111, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Record)

116. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in her care and treatment of patients C.D., W.B., C.B. and M.O., as more particularly alleged in paragraphs 16 through 111, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(Violation of Statutes Regulating Dangerous Drugs and Controlled Substances)

117. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2238 of the Code, in that respondent violated the pertinent regulations pertaining to proper methadone prescribing, including, but not limited to, 21 C.F.R. 1306.07, which prohibited him from prescribing methadone to patient W.B. to treat his history of heroin

addiction unless he was an approved narcotic treatment provider, as more particularly alleged in paragraphs 38 through 71, and 111, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Practicing Under False or Fictitious Name Without Fictitious Name Permit)

118. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2285, 2286, 2400, 2406 and 2415, of the Code, in that respondent practiced medicine under a fictitious name without a fictitious name permit issued by the licensing agency.

119. At all times relevant to the charges and allegations in this Accusation, respondent practiced medicine through his medical clinic which was named "Health and Longevity Institute" located in San Marcos, California.

120. On or about May 12, 2016, the Medical Board of California confirmed that respondent had not been issued a Fictitious Name Permit for "Health and Longevity Institute."

DISCIPLINARY CONSIDERATIONS

121. To determine the degree of discipline, if any, to be imposed on respondent, complainant alleges that a First Amended Accusation was filed against respondent on or about November 29, 2007, in a prior disciplinary action entitled *In the Matter of the Accusation against: Gary James Shima, M.D.*, Medical Board of California Case No. 10-2006-172800. The aforementioned First Amended Accusation alleged that respondent engaged in unprofessional conduct when violated laws by administering "oral Phytokem B17" also known as Laetrile, to a patient with metastatic melanoma, who had purchased the Laetrile in Mexico. On August 15, 2008, respondent's medical license was revoked, the revocation was stayed, and respondent was placed on probation for two and one-half (2.5) years probation, on various terms and conditions, including successful completion of an ethics course, successful completion of a clinical training program, and the other standard terms and conditions of probation. That decision is now final and is incorporated by reference as if fully set forth herein.

////

////

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G14742, issued to respondent Gary James Shima, M.D.;

2. Revoking, suspending or denying approval of Gary Shima, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Gary James Shima, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: June 23, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SD2014707565
81378681.docx